KANSAS HEALTH CARE STABILIZATION FUND NOTICE OF BASIC COVERAGE FORM (May 2009)

Kansas law requires the insurance company to forward this completed form and HCSF surcharge payment to the Kansas Health Care Stabilization Fund Board of Governors within thirty days of the date the insurer receives the basic coverage premium. A copy of this completed form must also be furnished to the health care provider.

FOR HCSF USE ONLY

SECTION I Individual Health Care Provider's Name , designation of M.D., D.O., D.C., D.P.M. or R.N.A. or the name of the health care provider entity (professional association, partnership, hospital or other health care provider organization).

Health Care Provider's Name _____
LAST NAME (OR FULL NAME OF HEALTH CARE PROVIDER ENTITY), FIRST NAME, MIDDLE INITIAL AND PROFESSIONAL DESIGNATION

Residence Address: _____ Daytime Phone Number: _____

City: _____ State: _____ Zip: _____

Business Address Of Health Care Provider: _____

SECTION II Coverage Limit Selection -First time Health Care Provider Signature Required.

☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

_____ _____
Date Signed Health Care Provider Signature

NOTE: FUND LIMITS CANNOT BE INCREASED USING THIS FORM. ALL INCREASES MUST BE APPROVED BY THE BOARD OF GOVERNORS. CONTACT THE HCSF OFFICE FOR THE NECESSARY DOCUMENTS.

SECTION III Insurance Policy Information And Health Care Stabilization Fund Surcharge Payment

					For Fund Classes 1 to 14	For Fund Classes 15 to 21	
HCSF Rate Classification Number	Provider's License, Registration or Certification Number	Basic Coverage Premium Amount	Number of Fund Compliance Years	HCSF Class Group No.	HCSF Surcharge Payment From Rate Tables	HCSF Surcharge Percent	HCSF % Based Surcharge Payment

_____
NAME OF INSURANCE COMPANY

NAME OF INSURANCE AGENT OR COMPANY REPRESENTITIVE

_____
TELEPHONE NUMBER AND E'MAIL ADDRESS OF INSURANCE AGENT OR COMPANY REPRESENTATIVE

The published HCSF surcharge for Fund classes 1 to 15 was modified for the following reason or reasons:

☐ THE POLICY IS SUBJECT TO A PART-TIME PRACTICE CREDIT RATING RULE APPROVED FOR USE BY THE BASIC PROFESSIONAL LIABILITY INSURER. THE PART-TIME FACTOR USED WAS _____%

☐ THIS KANSAS RESIDENT HEALTH CARE PROVIDER HAS AN ACTIVE MISSOURI LICENSE AND THE 25% MODIFICATION FACTOR WAS INCLUDED IN THE ABOVE SURCHARGE.

Policy Number: _____

Type of Basic Coverage Professional Liability Policy
☐ Occurrence ☐ Claims Made

Inception Date: _____
OF THE BASIC PROFESSIONAL LIABILITY INSRUANCE POLICY PERIOD

Coverage Effective Date: _____
ENTER DATE THIS HEALTH CARE PROVIDER WAS ADDED TO AN EXISTING POLICY PERIOD

Expiration Date: _____
OF THE BASIC PROFESSIONAL LAIBILITY INSURANCE POLICY PERIOD

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Notice to Health Care Provider: If you should discontinue your basic professional liability insurance policy because you are no longer rendering professional services as a Kansas resident health care provider, you should immediately contact the Kansas Health Care Stabilization Fund Board of Governors and request information regarding the availability of the Health Care Stabilization Fund's continuing coverage for inactive health care providers.

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